



The Commonwealth of Massachusetts  
Department of Public Health, Bureau of Health Professions Licensure  
Prescription Monitoring Program  
239 Causeway Street, Suite 500, Boston, MA 02114  
Phone: 617-753-7310 Fax: 617-973-0985

**Massachusetts Request for Annual Waiver of Daily Data Submission**

In Accordance with the Controlled Substances Act, M.G.L. Chapter 94C

Pharmacies that do not dispense Controlled Substances in Schedules II-V or any additional drugs that the Department has determined must be reported to the PMP may complete this form to request a waiver of the requirements that pharmacies must report to the PMP. Please submit to the Department by July 1<sup>st</sup> of each year via email to: [mapmp.dph@State.MA.US](mailto:mapmp.dph@State.MA.US)

<b>Business Type (select one):</b> <input type="checkbox"/> MA Pharmacy <input type="checkbox"/> Out of State Pharmacy <input type="checkbox"/> VA Pharmacy <input type="checkbox"/> Mail Order Pharmacy	<b>Please provide all applicable license number(s) for your facility:</b> <input type="checkbox"/> National Provider Identifier (NPI): <input type="checkbox"/> Drug Enforcement Administration (DEA): <input type="checkbox"/> Massachusetts Board of Pharmacy (MBOP):
<b>Reason for Waiver:</b>	
<b>Waiver Status:</b> <input type="checkbox"/> Renewal <input type="checkbox"/> New Request	
<b>Business Information</b>	
Business Name:	Facility Name (if applicable):
Business Address:	City: ZIP:
Business Phone: ( ) - - Ext:	Business Website:
Business Contact Name:	
Business Contact Phone: ( ) - - Ext:	
Business Email Address:	

<b>Pharmacist In Charge (PIC)</b>
PIC Name:
PIC Phone: ( ) - - Ext:
PIC Email Address:

<b>IT/ Software Vendor (if applicable)</b>
Vendor Name:
Vendor Product Name/Version:
Primary Contact for Software Vendor:
Vendor Phone: ( ) - - Ext:
Vendor Email Address:

***I hereby certify that the information on this application is true to the best of my knowledge and that my pharmacy does not dispense any controlled substances that must be reported to the PMP.***

***Requesting Authority:***

Name:	Signature:	Date:
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***DPH USE ONLY***

Approved by:	Signature:	Date:
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